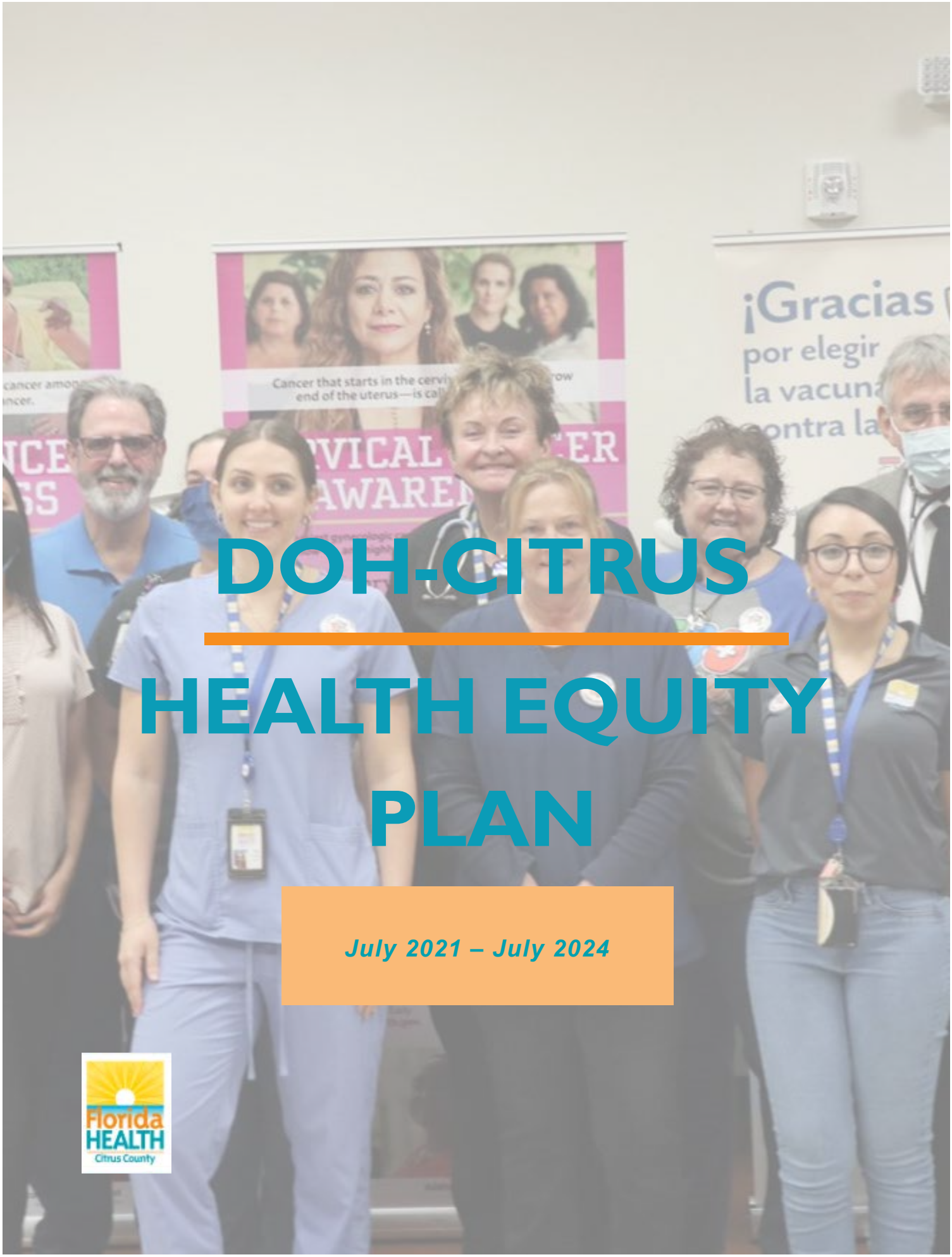


DOH-CITRUS

HEALTH EQUITY PLAN

July 2021 – July 2024

Florida HEALTH
Citrus County

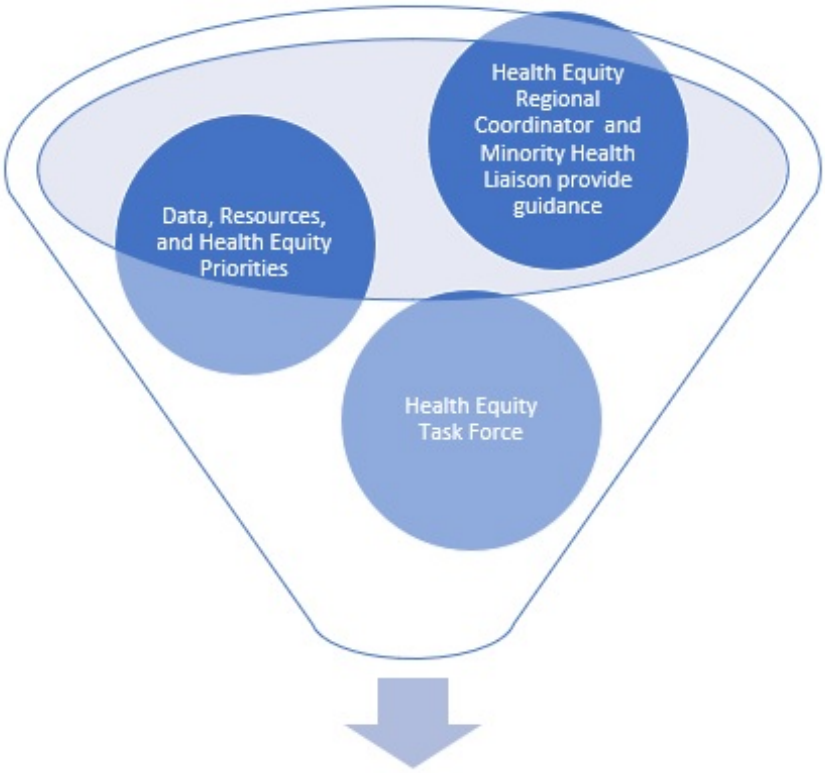
Table of Contents

I. VISION

"Healthiest state in the nation", in part, is Florida DOH's vision statement. The process for Heath Equity (HE) was to involve CHD leadership in reviewing multiple suggested vision statements; narrowing the options to three. Finalization of the vision was done by the Health Equity and Disparities Coalition (HEDC). Options: #1 "Citrus County will lead the state in health equity"; #2 "To strive to eliminate disparities in health outcomes due to race, ethnicity, gender, age, geography, and socioeconomic status." (https://www.centerforhealthequity.com/mission); or option #3 "A county where all people live in thriving communities where resources work well, systems are equitable and create no harm, and everyone has the power to achieve optimal health and each provider is equipped with the consciousness, tools and resources to confront inequities as well as embed and advance equity within and across all aspects of the health system" (https://www.ama-assn.org/about/ama-center-health-equity/ama-s-center-health-equity-mission-and-guiding-principles.

The HEDC's Vision statement:

The HEDC strives to eliminate disparities in health outcomes due to race, ethnicity, gender, age, geography, and socioeconomic status.



Health Equity Vision

II. PURPOSE OF THE HEALTH EQUITY PLAN

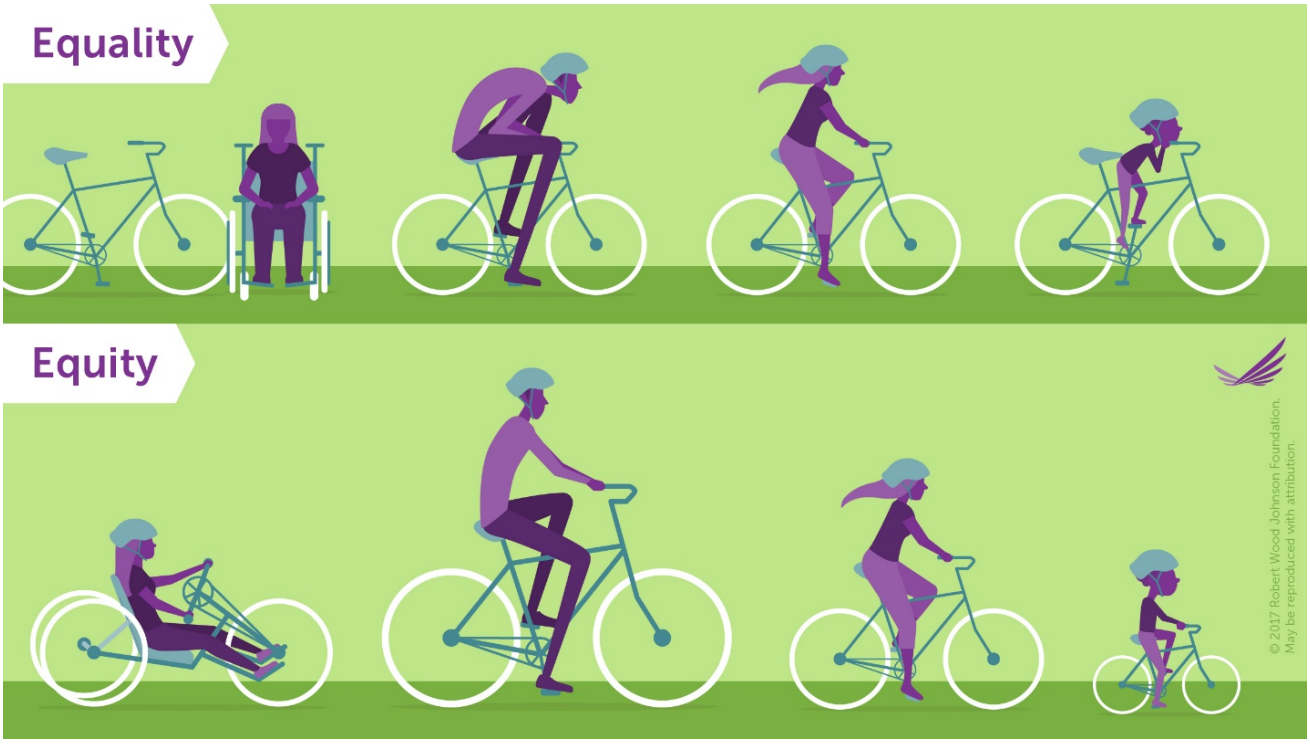
Health Equity is achieved when everyone can attain optimal health.

The Florida Department of Health's Office of Minority Health and Health Equity (OMHHE) works with government agencies and community organizations to address the barriers inhibiting populations from reaching optimal health. A focus on health equity means recognizing and eliminating the systemic barriers that have produced disparities in achieving wellness. In response to Chapter 2021-1700 of the Florida Statute, effective July 1, 2021, each county health department (CHD) has been provided resources to create a Health Equity Plan to address health disparities in their communities.

The Health Equity Plan should guide counties in their efforts to create and improve systems and opportunities to achieve optimal health for all residents, especially vulnerable populations. County organizations have a critical role in addressing the social determinants of health (SDOHs) by fostering multi-sector and multi-level partnerships, conducting surveillance, and integrating data from multiple sources, and leading approaches to develop upstream policies and solutions. This plan acknowledges that collaborative initiatives to address the SDOHs are the most effective at reducing health disparities.

The purpose of the Health Equity Plan is to increase health equity within Citrus County. To develop this plan, Citrus County health department followed the Florida Department of Health's approach of multi-sector engagement to analyze data and resources, coordinate existing efforts, and establish collaborative initiatives. This plan addresses key SDOH indicators affecting health disparities within Citrus County. This Health Equity Plan is not a county health department plan; it is a county-wide Health Equity Plan through which the Health Equity Task Force, including a variety of government, non-profit, and other community organizations, align to address the SDOH impact health and well-being in the county.

III. DEFINITIONS



Health equity is achieved when everyone can attain optimal health

Health inequities are systematic differences in the opportunities groups have to achieve optimal health, leading to avoidable differences in health outcomes.

Health disparities are the quantifiable differences, when comparing two groups, on a particular measure of health. Health disparities are typically reported as rate, proportion, mean, or some other measure.

Equality each individual or group of people is given the same resources or opportunities.

Social determinants of health are the conditions in which people are born, grow, learn, work, live, worship, and age that influence the health of people and communities.

IV. PARTICIPATION

Cross-sector collaborations and partnerships are essential components of improving health and well-being. Cross-sector collaboration uncovers the impact of education, health care access and quality, economic stability, social and community context, neighborhood and built environment and other factors influencing the well-being of populations. Cross-sector partners provide the range of expertise necessary to develop and implement the Health Equity Plan.

World's Greatest Baby Shower event. This is an annual event with an average of over 30 cross-sector organizations coming together to provide education and resources to families. DOH-Citrus programs include Healthy Start, WIC, School-Based Dental Program, Healthy Babies, Community Health, and Women's Health. These programs provide education and information that cover topics such as healthy lifestyles, child safety, early learning, positive parenting, and much more.

A. Minority Health Liaison

The Minority Health Liaison supports the Office of Minority Health and Health Equity in advancing health equity and improving health outcomes of racial and ethnic minorities and other vulnerable populations through partnership engagement, health equity planning, and implementation of health equity projects to improve social determinants of health. The Minority Health Liaison facilitates health equity discussions, initiatives, and collaborations related to elevating the shared efforts of the county.

Minority Health Liaison: Vanessa Verdo, IBCLC 9/21-6/22
Kathryn DeFranco 7/22-Current
Minority Health Co-Liaison: BJ Ezell, DrPH, RN

B. Health Equity Team

The Health Equity Team includes individuals that each represent a different program within the CHD. The Health Equity Team explores opportunities to improve health equity efforts within the county health department. Members of the Health Equity Team assess the current understanding of health equity within their program and strategize ways to improve it. The Health Equity Team also relays information and data concerning key health disparities and SDOH in Citrus County to the Health Equity Task Force. The Minority Health Liaison guides these discussions and the implementation of initiatives. The membership of the Health Equity Team is listed below.

Name	Title	Program
Linda Rice	PMQI Champion	Government Operations
Tito Rubio	Administrator	Health Officer Citrus County
Merton J. Rashley	Asst. Director	Environmental Health
Joshua Ramirez	Director II	Administrative Services (Finance)
Janora Wade	Director	Community Health Nursing
Anne Murphy	Personnel Liaison	Government Operations (Human Relations)

Juliann Velez	Coordinator	WIC Program in Citrus County
Carmen Hernandez	Program Administrator	Community Health Program
Sandra Child	Nursing Supervisor	Community Health Program
Michelle Davis	Nursing Supervisor	Community Health Program
Glenn Bryant	Director	Environmental Health
Vanessa Verdo	Health Educator Consultant Liaison	Health Equity & Disparities Program
Raquel Gonzalez	Dental Hygienist	Dental Program
Amy Douglas	Public Information Officer	APR, Government Operations Consultant II
BJ Ezell	DrPH, RN/Co-Liaison	Health Equity & Disparities Program

The Health Equity Team met on the below dates during the health equity planning process. Since the Health Equity Plan was completed, the Health Equity Team has met at least quarterly to track progress.

Meeting Date	Topic/Purpose
10/26/2021	Make Health Equity a Strategic Priority
11/2/2021	Build Infrastructure to Support Health Equity
11/9/2021	Address the Multiple Determinants of Health
11/30/2021	Eliminate Racism & Other Forms of Oppression
12/7/2021	Partner with Community to Improve Health Equity
12/14/2021	IHI Assessment Priorities and Strategies

C. Health Equity Task Force

The Health Equity Task Force includes CHD staff and representatives from various organizations that provide services to address various SDOH. Members of this task force brought their knowledge about community needs and SDOH. Collaboration within this group addresses upstream factors to achieve health equity. The Health Equity Task Force wrote the Citrus County Health Equity Plan

and oversaw the design and implementation of projects. Health Equity Task Force members are listed below.

Name	Title	Organization	Social Determinant of Health
Tito Rubio	Administrator/ Health Officer	DOH-Citrus County	Health Care Access and Quality
Carmen Hernandez	Community Health Program Administrator	DOH-Citrus County	Social and Community Context
Nancy Witty	Community Operations Consultant	DOH-Citrus County	Health Care Access and Quality
Tito Rubio	Administrator/ Health Officer	DOH-Citrus County	Neighborhood and Built Environment
Janora Wade	Community Health Nursing Director	DOH-Citrus County	Health Care Access and Quality
Merton J. Rashley	Asst. Director	DOH-Citrus County	Neighborhood and Built Environment
Lisa Woolston	Associate VP of Citrus County Services	LifeStream Behavioral Center	Neighborhood and Built Environment
Vanessa Verdo	Minority Health Liaison	DOH-Citrus County	Health Care Access and Quality
Betty Ezell (BJ)	Co-Minority Health Liaison	DOH-Citrus County	Health Care Access and Quality
Lynsie Cahela	Support Services Director	Board of Citrus County Commissioners	Neighborhood and Built Environment

The Health Equity Task Force met on the below dates during the health equity planning process. Since the Health Equity Plan was completed, the Health Equity Task Force has continued to meet at least quarterly to track progress.

Meeting Date	Organizations	Topic/Purpose
10/26/2021	DOH Citrus	Make Health Equity a Strategic Priority
11/2/2021	DOH Citrus	Build Infrastructure to Support Health Equity
11/9/2021	DOH Citrus	Address the Multiple Determinants of Health
11/30/2021	DOH Citrus	Eliminate Racism & Other Forms of Oppression
12/7/2021	DOH Citrus	Partner with Community to Improve Health Equity
12/14/2021	DOH Citrus	IHI Assessment Priorities and Strategies

D. FDOH Office of Minority Health and Health Equity Grant Status Meetings

The FDOH Office of Minority Health and Health Equity Grant Status Group meets weekly beginning December 2021, to discuss goals, objectives and activities related to Minority Health Plan.

Name	Title	Program
Vanessa Verdo	Minority Health Liaison	DOH-Citrus County
Dr. BJ Ezell	Co-Minority Health Liaison	DOH-Citrus County
Janora Wade	Community Health Nursing Director	DOH-Citrus County
Kathryn DeFranco	Minority Health Liaison (as of 7/2022)	DOH-Citrus County

E. Coalition

The Coalition discussed strategies to improve the health of the community. The strategies focused on the social determinants of health: education access and

quality, health care access and quality, economic stability, social and community context, and neighborhood and built environment. Membership includes community leaders working to address each SDOH, as well as any relevant sub-SDOHs. The Coalition assisted the Health Equity Task Force by reviewing their Health Equity Plan for feasibility.

Name	Title	Program
Jerry Belloit	Retired Pastor, Trustee	Floral City United Methodist Church
Florence Langley-Dunham	Pastor	Mt. Carmel Methodist Church – Floral City
Keith Dendy	Pastor	First Baptist Church of Hernando
Phyllis Bell	Secretary	The New Church Without Walls International - Lecanto
Dr. Jeff Wallis	Medical Director	Doctors' Free Clinic of Citrus County (DFCCC)
Karla Poulos	Clinical Supervisor	Doctors' Free Clinic of Citrus County (DFCCC)
Frank Di Piazza	Executive Director	The Florida WellCare Alliance, LLC
George Ann Jackson	President	Citrus County Democratic Black Caucus
Delphina Hopkins-Gillispie	Member	Afro-American Club of Citrus County
Melvenia Houston	Proprietor	Houston's Beauty Supply
Lauryn Scruggs	Student	USF Public Health Masters

Meeting Date	Topic/Purpose
1/12/2022	Introductions and goals
1/26/2022	Discussion of National Minority Health Month (NMHM) event in April 2022; promotional material ideas

2/9/2022	NMHM event updates and advertising ideas; quotes for promotional items
2/23/2022	Promotional materials updates; NMHM event updates; future team meetings; Black History Month event invitation
3/16/2022	Strawberry Festival event updates; Planning of April Minority Health Month Event; Coalition Opportunities
4/20/2022	New member George Ann Jackson, President of the Citrus County Democratic Black Caucus. New member Karla Poulos, Doctors' Free Clinic of Citrus County, Executive Director first meeting. Successful National Minority Health Month (NMHM) event April 9, 2022. Three proclamations for NMHM read into minutes for Board of County Commissioners minutes, City of Inverness & the City of Crystal River. Community Awareness Speaking Engagements: Afro-American Club of Citrus County (Beverly Hills), 4/4/22 with 40 attendees. Citrus County Democratic Black Caucus 4/16/22 with 10 attendees. 4-minute education clip Equity Vs Equality – YouTube. Vision Statement 3 options.
5/18/2022	Vote on Vision Statement, Upcoming community events, and HE Plan status; open discussion needs and updates from community partners, food insecurity, departure, and plan to fill HE Liaison.
6/15/2022	New member(s) intro, Completed Events (Floral City United Methodist Church), Upcoming Event (The New Church Without Walls International); finalization of Vision statement, HE Template status, Community partners open discussion on community needs and updates, i.e., transportation, food insecurity.
7/27/2022	

F. Regional Health Equity Coordinators

There are eight Regional Health Equity Coordinators. These coordinators provide the Minority Health Liaison, Health Equity Team, and Health Equity Task Force with technical assistance, training, and project coordination.

Name	Region	Expertise
Carrie Rickman	Emerald Coast	Nursing
Quincy Wimberly	Capitol	Inclusive Strategies in Public Health and Technical Assistance
Diane Padilla	North Central	Non-Profit Engagement
Ida Wright	Northeast	Community Engagement and Project Management
Rafik Brooks	West	Health Care Leadership
Lesli Ahonkhai	Central	Faith-Based Engagement, Public Health Leadership, PH Workforce Capacity Building and Mentoring
Natasha McCoy (interim)	Southeast	Public Health Practice, Grant writing, and Partnerships
Frank Diaz-Gines	Southwest	Health Insurance

V. HEALTH EQUITY ASSESSMENT, TRAINING, AND PROMOTION

A. Health Equity Assessments

To improve health outcomes in Florida, it is critical to assess the knowledge, skills, organizational practices, and infrastructure necessary to health inequities. Health equity assessments are needed to achieve the following:

- Establish a baseline measure of capacity, skills, and areas for improvement to support health equity-focused activities
- Meet Public Health Administration Board (PHAB) Standards and Measures 11.1.4A which states, "The health department must provide an assessment of cultural and linguistic competence."
- Provide ongoing measures to assess progress towards identified goals developed to address health inequities
- Guide CHD strategic, health improvement, and workforce development planning
- Support training to advance health equity as a workforce and organizational practice

Citrus County conducted a health equity assessment(s) to examine the capacity and knowledge of Citrus County Health Department staff and to address social determinants of health. Citrus County is in the process of sending out and reviewing vendor bids for an assessment which when completed will provide a more current and complete status of health equity in the county. Below are the dates assessments were distributed and the partners who participated.

Citrus County has begun the process to complete a new Community Health Assessment (CHA). An assessment of health equity knowledge and needs will be included in the CHA. Expected completion date is Fall 2022. Health equity gaps and needs identified by the CHA will be included in the updated Citrus Community Health Improvement Plan and health equity plan will be updated.

Below are the dates assessments were distributed and the partners who participated.

Date	Assessment Name	Organizations Assessed
September 2021-December 14, 2021 (weekly)	Institute for Healthcare Improvement Improving Health Equity: Assessment Tool for Health Care Organization	DOH-Citrus
April 2022	Health Equity, Inequality, Biases (Implicit and Explicit)	DOH-Citrus

B. County Health Equity Training

Assessing the capacity and knowledge of health equity, through a forthcoming assessment, will contribute to the Minority Health Liaison identifying knowledge gaps and create training plans for the Health Equity Task Force, the Coalition, and other county partners.

Specific activities, conducted by the Health Equity Team, to develop a shared understanding of health equity in Citrus County will occur through training and dissemination of resources. Once standardized training material is rolled out to all counties, the Citrus County HE Coordinator will be trained. The HEC will then train others who will in turn train staff, HEDC, and other community partners. This will provide consistency in common terminology, goal, objectives, and role play to facilitate community-wide understanding of the issues and potential solutions related to health equity.

Below are the dates, SDOH training topics, and organizations who attended training.

Date	Topics	Organization(s) receiving trainings

C. County Health Department Health Equity Training

The Florida Department of Health in Citrus County (DOH-Citrus) recognizes that ongoing training in health equity and cultural competency are critical for creating a sustainable health equity focus. At a minimum, all DOH-Citrus staff receive the *Cultural Awareness: Introduction to Cultural Competency* and *Addressing Health Equity: A Public Health Essential* training. In addition, the Health Equity Team provides regular training to staff on health equity and cultural competency. The training is recorded below.

Date	Topics	Number of Staff in Attendance
10/2021	Introduction to Cultural Competency in Family Planning Care	96
12/17/2021	Causes of poor health outcomes, social determinants of health	96
12/17/2021	Book distributed to all staff: *Expanding the Boundaries: Health Equity and Public Health Practice*	96
4/13/2022	Equity vs. Equality - YouTube	96

A post-training health equity assessment will be conducted to assess the success of the training plan, with pertinent findings described. If a post training health equity assessment has not yet been conducted, an evaluation of the training plan will be conducted.

D. Minority Health Liaison Training

The Office of Minority Health and Health Equity and the Health Equity Regional Coordinator provide training and technical support to the Minority Health Liaison on topics such as: the health equity planning process and goals, facilitation, and prioritization techniques, reporting requirements, and taking a systems approach to address health disparities. The Minority Health Liaison training is recorded below.

Date	Topics
1/25/2022	Cultural Competency & Health Equity Training
4/19/22	Onboarding Training Part I (Cultural Competency)

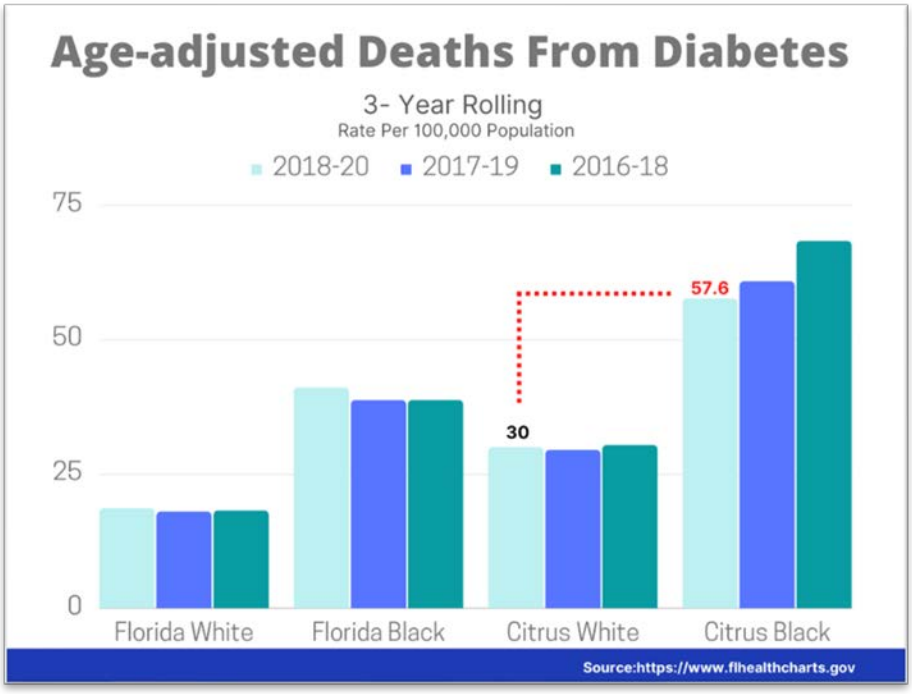
E. National Minority Health Month Promotion

Citrus County Department of Health hosted a National Minority Health Month event on April 9th, 2022, at the George Washington Carver Community Center, to bring awareness to health equity and disparities. No cost health screenings and education included low/no-cost car seat information, blood pressure screens, glucose, cholesterol & hemoglobin checks, safe sleep and breastfeeding, nutrition education and COVID-19 vaccinations. Other activities included a healthy snack demo, “plant your own veggie”, and drawings for donated kids’ toys. Additionally, in keeping with Health in All Policies (HiAP), 3 government proclamations for NMHM were read during county and city meetings by the City of Inverness (Bob Plastid), City of Crystal River (Joe Meek), & the Board of County Commissioners of Citrus County (Ronald E. Kitchen, Jr.) for all citizens awareness and action. *Please see Appendix A photos of government proclamations.

VI. PRIORITIZING A HEALTH DISPARITY

The Health Equity Team identified and reviewed health disparities data in Citrus County. The following health disparities were identified in Citrus County: hypertension, diabetes, cholesterol, COVID-19, and nutrition/healthy eating for kids. Using data tools such as FL Charts and County Health Rankings, the Health Equity Team decided to work on the chronic disease diabetes in the Health Equity Plan. Data concerning the chronic disease diabetes is below.

The focus is on vulnerable and marginalized populations such as racial minorities, ethnic minorities, LGBITQ+ populations, the elderly, children, communities with low socio-economic status, people with disabilities, people in rural areas, people in food deserts, and other groups at risk for health disparities.



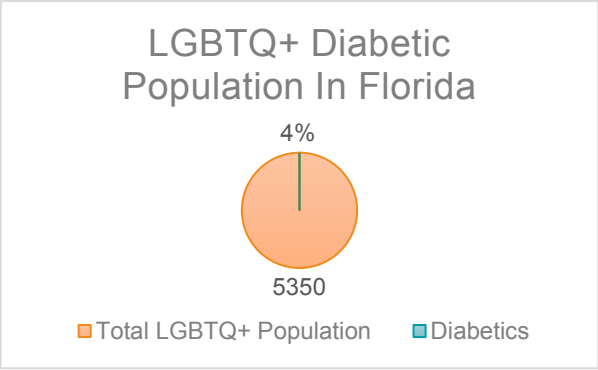
Note: Some priority populations mentioned do not have much, if any data on diabetes specific to Veteran, LGBTQ+, Asian/Pacific Islander, etc. A proposed project is the gathering of more data on these populations. Data overlap, especially related to economic and geographic indicators among populations within the chosen primary, secondary and tertiary populations is likely. However, the resulting information could be invaluable in identifying and approaching solutions to inequities and disparities among the priority populations.

The Behavioral Risk Factor Surveillance System (BRFSS) is an annual statewide random telephone and cellular surveillance survey designed by the Centers for Disease Control and Prevention (CDC). The survey is conducted in all 50 states and US territories. BRFSS monitors modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality in the population. Data from the BRFSS are useful for planning, initiating, and supporting health promotion and disease prevention programs at the state and federal level, and monitoring progress toward achieving health objectives for the state and nation. New York State's BRFSS sample is representative of the non-institutionalized civilian adult population, aged 18 years and older (https://www.health.ny.gov/statistics/brfss/, 2022). The LGBTQ+ [lesbian, gay, bisexual, transgender, queer (or questioning), intersex, and asexual (or allies)] data is from the BRFSS by CDC's Office of Minority Health & Health Equity (OMHHE). Many indicators were not statistically significant, even though the values were very different, due to the small number of respondents. A confidence interval displays the probability that a parameter will fall between a pair of values around the mean. Confidence intervals measure the degree of uncertainty or certainty in a sampling method. They are most often constructed using confidence levels of 95% or 99%. (The confidence intervals were just too big). The results presented here are those that were statistically significant for Florida:

The BRFSS survey is conducted by phone calls to landlines; however, the trend is that the younger generation does not use landlines, opting instead for cell phones. Citrus County would need to have at least 30 LGBTQ+ respondents for the capture of county-level data; otherwise, the state level data is extrapolated to the county level.

The LGBTQ+ data from the BRFSS presented by the OMHHE did not produce county level data for Citrus County. However, viewing the statewide data suggests there is significant data that Citrus County should consider in addressing this issue for the LGBTQ+ population in Citrus County. Of 5,350 LGBTQ+ surveyed in Florida 227 were found to have been told they have been diabetic.

Many indicators were not statistically significant, even though the values were very different, due to the small number of respondents. State level data will be used in future projects, as Citrus County did not have at least 30 LGBTQ+ respondents. Additional Data collection processes including the use of media agencies, such as COMMANDO, to get more inclusive Citrus County LGBTQ+ data will be utilized in future projects.



In similar manner the BRFSS was used to explore people living with disabilities in Citrus County among the civilian adult population, aged 18 to 65 years of age. One (Pre-Diabetes) of five indicators was statistically significant.

There is no statistically significant difference in Diabetes scores between People Living With At Least One Disability (mean = 0.18, N = 76) and People Living with Zero Disabilities (0.12, N = 88).

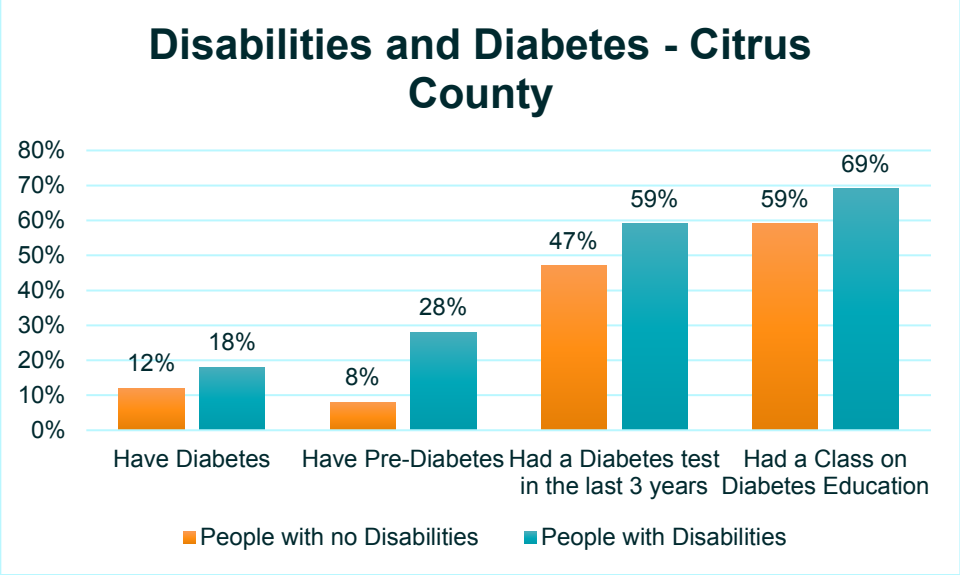
There is no statistically significant difference in Age Diagnosed with Diabetes between People Living With At Least One Disability (mean = 45.99, N = 11) and People Living with Zero Disabilities (41.18, N = 8).

There is statistically significant difference in Pre-Diabetes between People Living With At Least One Disability (mean = 0.28, N = 63) and People Living with Zero Disabilities (0.08, N = 77). The test passed baseline statistical standards ($p<0.05$). It is 95.0% likely that difference is not due to random chance and indicates a meaningful difference between the two groups. The results that are significant, indicate the results are statistically meaningful and not the result of random chance

There is no statistically significant difference in Had Diabetes Test in Last 3 Years between People Living With At Least One Disability (mean = 0.59, N = 62) and People Living with Zero Disabilities (0.47, N = 75).

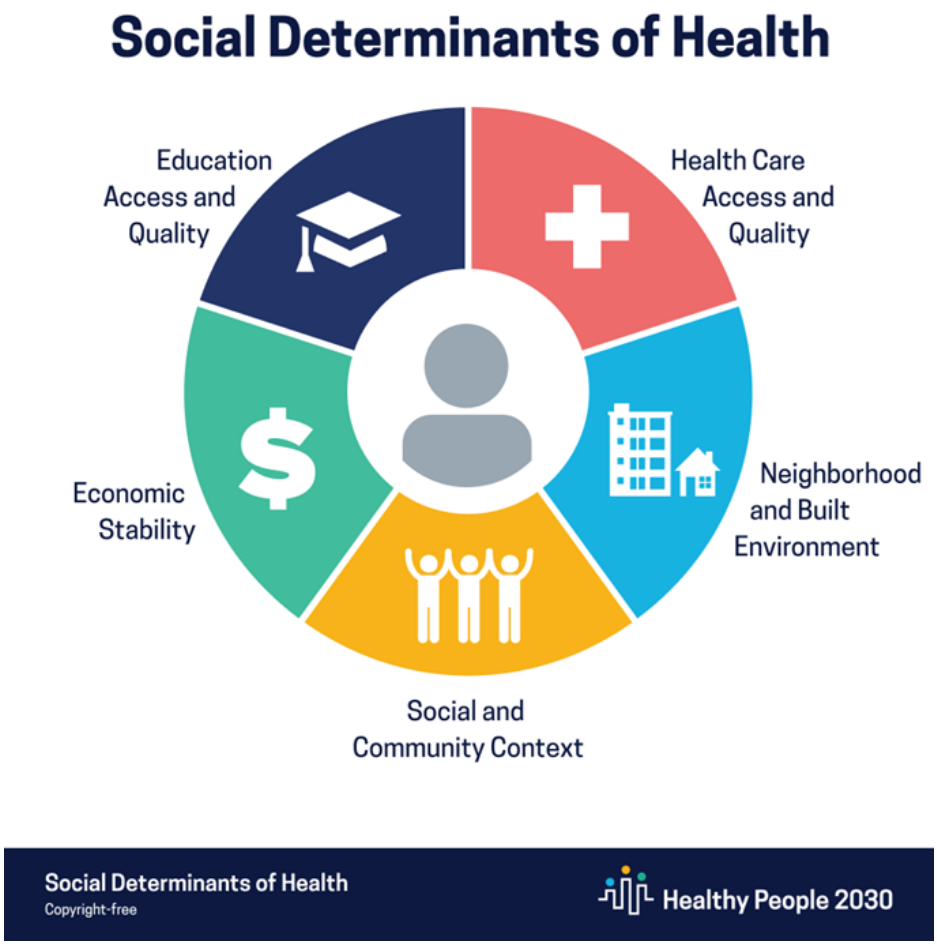
There is no statistically significant difference in Had Diabetes Test in Last 3 Years between People Living With At Least One Disability (mean = 0.69, N = 10) and People Living with Zero Disabilities (0.59, N = 8).

Where some indicators were not statistically significant at the county level, state level data will be used in future projects as the county did not have at least 30 respondents in some categories. The total population of respondents for Diabetes (mean = 0.14, N = 166); Age Diagnosed with Diabetes (mean = 43.90, N = 19), Pre-Diabetes (mean = 0.16, N = 142), Had Diabetes Test in Last 3 Years (mean = 0.51, N = 139), and Had Class on Diabetes Education (mean = 0.65, N = 18). Additional data collection processes including the use of media and data collection agencies to get more inclusive Citrus County data will be utilized in future projects.


Disabilities and Diabetes - Citrus County
80%
70%
60%
50%
40%
30%
20%
10%
0%
12%
18%
8%
28%
47%
59%
59%
69%
Have Diabetes
Have Pre-Diabetes
Had a Diabetes test in the last 3 years
Had a Class on Diabetes Education
People with no Disabilities
People with Disabilities

VII. SDOH DATA

Social Determinants of Health (SDOHs) are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes. The SDOHs can be broken into the following categories: education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability. The Health Equity Team identified multiple SDOHs that impact chronic diseases. They are listed below.

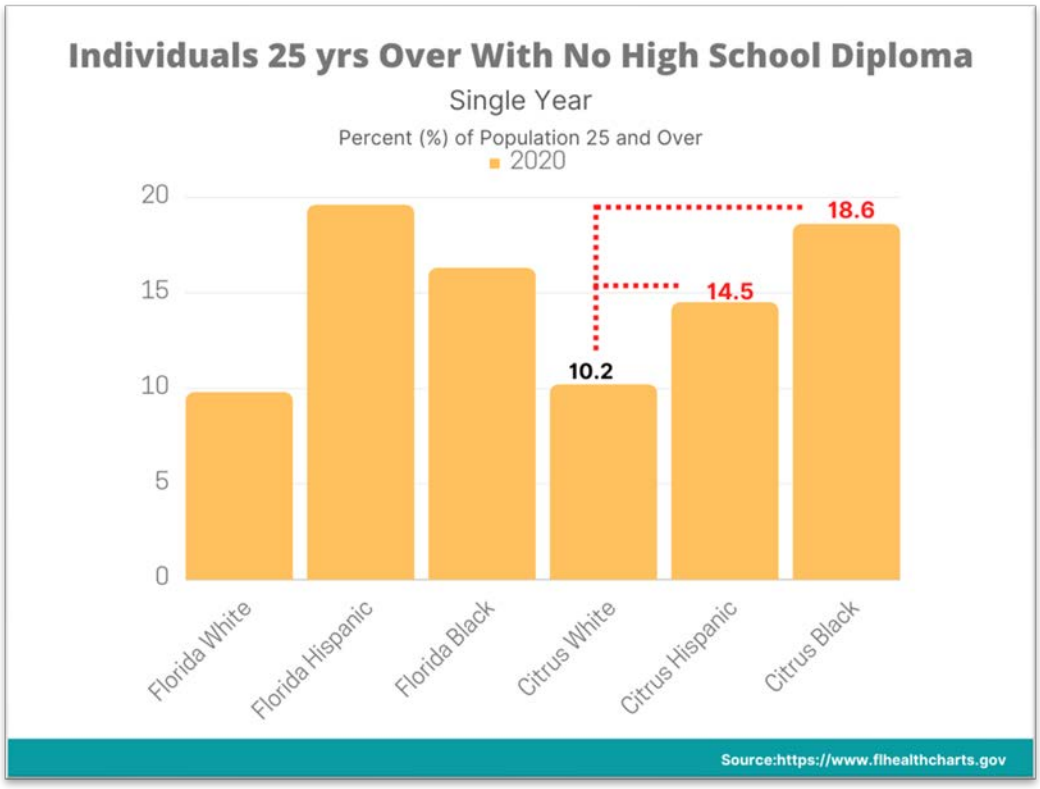


A. Education Access and Quality

- **Education Access and Quality data for Citrus County**

Individuals 25 Years and over with No High School Diploma by Ethnicity

In 2019, the percentage of individuals 25 years and over with no high school diploma in Citrus County was 11.6% compared to Florida at 11.8%. The percentage of Hispanic individuals 25 years and over in Citrus County with no high school diploma was 22.7% compared to non-Hispanic individuals at 11.0%. The line graph shows change over time. Failure to receive a high school diploma can lead to poor eating and exercise habits as well as increased risk of chronic diseases such as diabetes. Addressing chronic disease like diabetes as early as high school provides education about the disease to mitigate the impact of the disease.

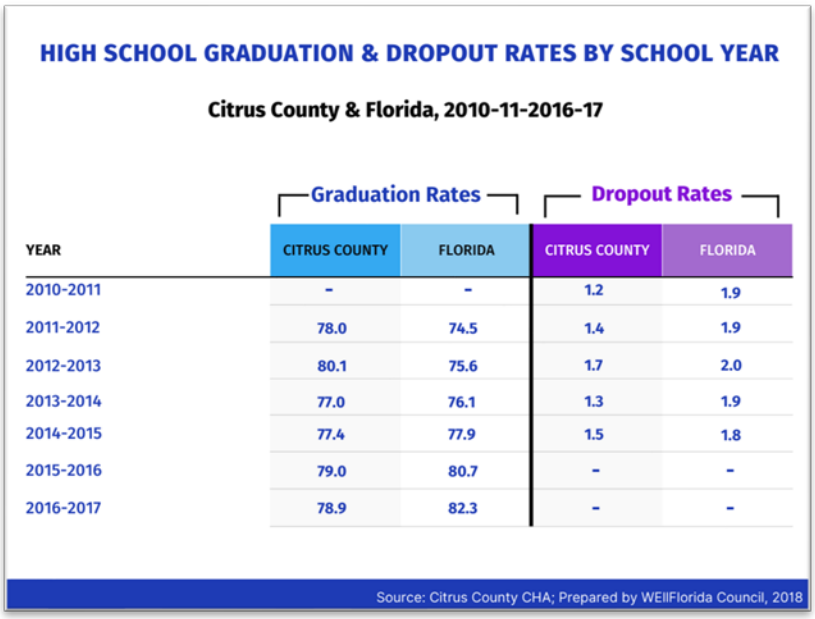


Graduation and Dropout Rates

During the 2011-2012, 2012-2013, and 2013-2014 school years, the Citrus County graduation rates were all higher than the Florida averages (78.0% v. 74.5%, 80.1% v. 75.6%, and 77.0% v. 76.1%, respectively). However, this trend flipped during the 2014-2015, 2015-2016, and 2016-2017 school years, where the graduation rate in Citrus County was lower than Florida's averages (77.4% v. 77.9%, 79.0% v. 80.7%, and 78.9% v. 82.3%, respectively). Additionally, all school years from 2011-2015 had lower dropout rates in Citrus County compared to Florida as a whole. Diabetes is the seventh leading cause of death in the US. The process and impact exist for disease reduction in the number of cases, complications, and deaths. Education and early diagnosis can impact undiagnosed, poorly controlled, or untreated diabetes. The impact can be seen in the amputation of a leg or foot, vision loss, and kidney damage. The process to reduce the impact would be interventions focused on disease management to help reduce the risk of complications. Strategies that promote knowledge about healthier eating, physical activity, and weight loss can prevent new cases (Healthy People 2020/2030). Evidence shows that people with prediabetes who finish structured lifestyle change programs have a lower risk of developing diabetes (Health People 2020/2030). Citrus County is addressing this issue with a holistic approach inclusive of the family and not just the prediabetic or diabetic with a 6-week diabetes management course at the health department, businesses, and other events. A high

school education or greater represents the more likely information is absorbed and the concepts of diabetes cause adjustments to activities of daily living to prevent and manage diabetes. More education means the likelihood of stable jobs that provide health-promoting benefits like health insurance, paid leave, and retirement. Conversely, less education can mean few if any health benefits, limited access to care, struggles for necessities of food and shelter, and the inevitable long-term generational cycle of poverty.

To improve chronic diseases, Citrus County is addressing ethnic disparities related to graduating high school. The Citrus County dropout rate is consistently lower than the overall Florida dropout rate.



HIGH SCHOOL GRADUATION & DROPOUT RATES BY SCHOOL YEAR

Citrus County & Florida, 2010-11-2016-17

	Graduation Rates		Dropout Rates	
YEAR	CITRUS COUNTY	FLORIDA	CITRUS COUNTY	FLORIDA
2010-2011	-	-	1.2	1.9
2011-2012	78.0	74.5	1.4	1.9
2012-2013	80.1	75.6	1.7	2.0
2013-2014	77.0	76.1	1.3	1.9
2014-2015	77.4	77.9	1.5	1.8
2015-2016	79.0	80.7	-	-
2016-2017	78.9	82.3	-	-

Source: Citrus County CHA; Prepared by WellFlorida Council, 2018

Source: Citrus County CHA; Prepared by WellFlorida Council, 2018

- The impact of education access and quality on diabetes

Education Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Literacy	Low-income, Black, Hispanic, and other minorities	Individuals with lower literacy are 1.5-3 times more likely to experience poorer health outcomes and therefore are at an increased risk for chronic diseases, such as diabetes.
Language	Low-income, Black, Hispanic, and other minorities	Language barriers reduce the level of patient and provider communication. This can impact the quality of care received as well as patient understanding of long-term management plans of diabetes and other health conditions. Adverse health events are more

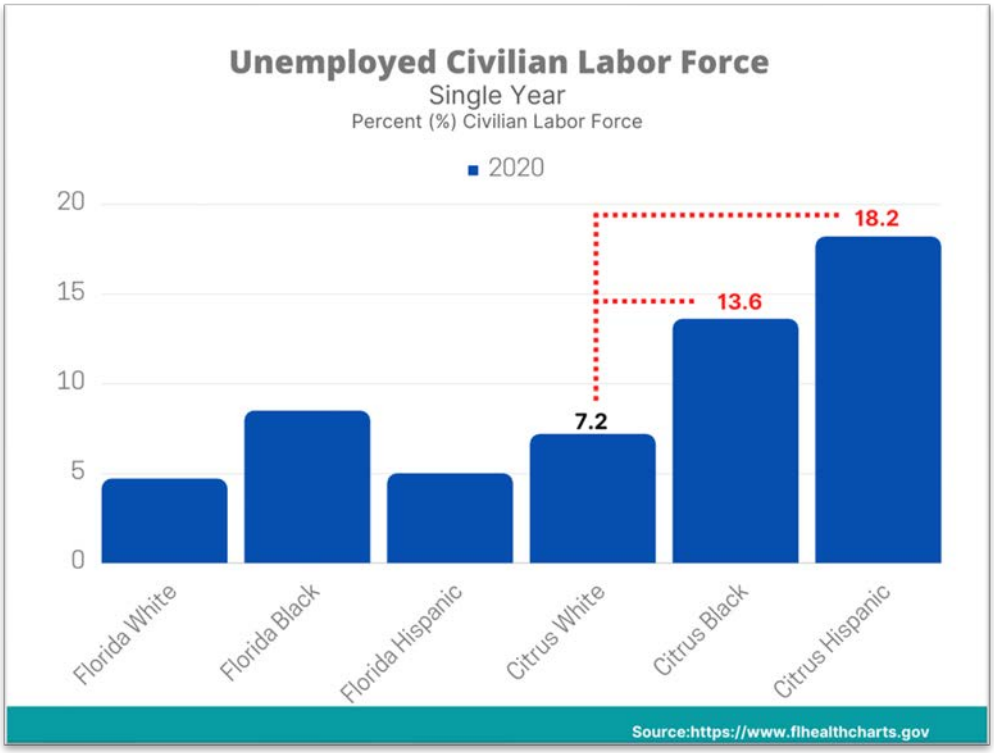
		likely to occur in individuals who have limited English proficiency.
Early Childhood Development	Low-income, Black, Hispanic, and other minorities	Exposure to environmental hazards, adverse events, early life stress and socioeconomic status of young children's families impact mental and physical health. These factors increase the risk of developing chronic disease like diabetes later in life.
Vocational Training	Low-income, Black, Hispanic, and other minorities	Inadequate diet, risky health behaviors such as alcohol and tobacco use, obesity, physical inactivity, anxiety, and depression often begin during adolescence and the young adult years. Enrollment in vocational programs includes individuals in these age groups. Vocational students are more likely to work full time at an earlier age and experience increased levels of stress and anxiety and as a result lead to and increase engagement in health risk behaviors ultimately leading to an increase incidence of chronic diseases, such as diabetes.
Higher Education	Low-income, Black, Hispanic, and other minorities	Studies show that when an individual drops out of high school, they have reduced life opportunities such as employment stability, poor eating and exercise habits and risk of diabetes.

B. Economic Stability

- **Economic stability data for Citrus County**

Unemployment

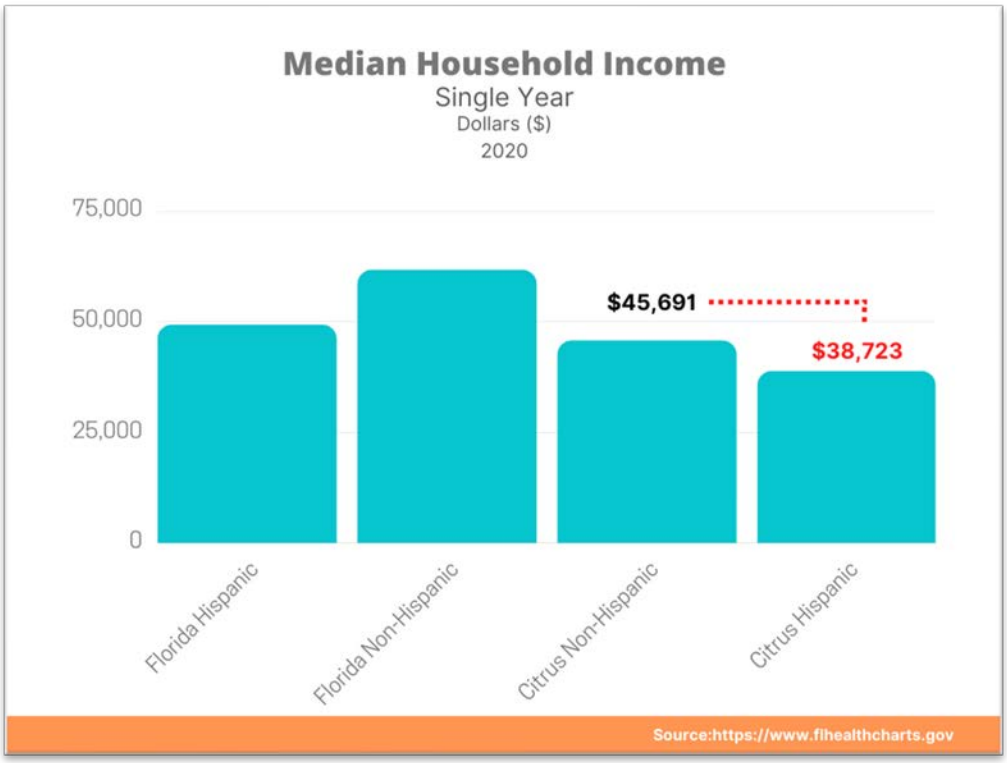
In 2019, the percentage of the civilian labor force who are unemployed in Citrus County was 8.0% compared to Florida at 5.6%. The percentage of Hispanic civilians who are unemployed in Citrus County was 12.5%, compared to non-Hispanic individuals at 7.5%. The line graph shows change over time. Civilian unemployment impacts chronic diseases by creating barriers to healthy food access, health insurance and access to health services, all of which have an impact on long-term management of chronic diseases such as diabetes.

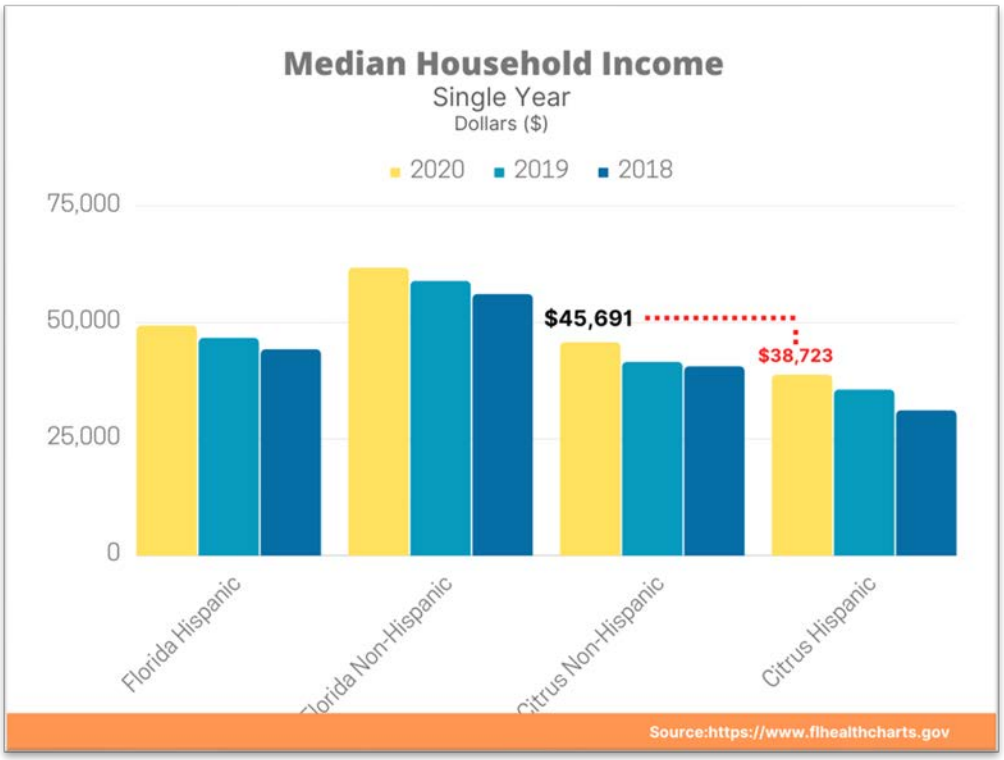


Median Household Income

In 2019, the median household income in Citrus County was $44,237 compared to Florida at $55,660. The median household income of Hispanic individuals in Citrus County was $38,723 compared to non-Hispanic individuals at $44,406. The line graph shows change over time. A good median household income impacts chronic diseases by earning a steady income that allows people to meet their health needs. With 1 in 10 Americans living in poverty, there is little ability to afford healthy foods, health care, and housing. Steady income above the poverty level makes it more likely people are healthy. Compounding poverty, people with disabilities, injuries, or conditions like diabetes may be especially limited in their ability to work and keep a job. Citrus County sees people at or near the poverty level who may not know there are community resources that can help. The Health Department in conjunction with other county programs refer people to employment programs, career counseling, and high-quality childcare opportunities so job seekers can acquire employment. In addition, giving people knowledge about public health policies related to acquiring food, housing, health care, and even education

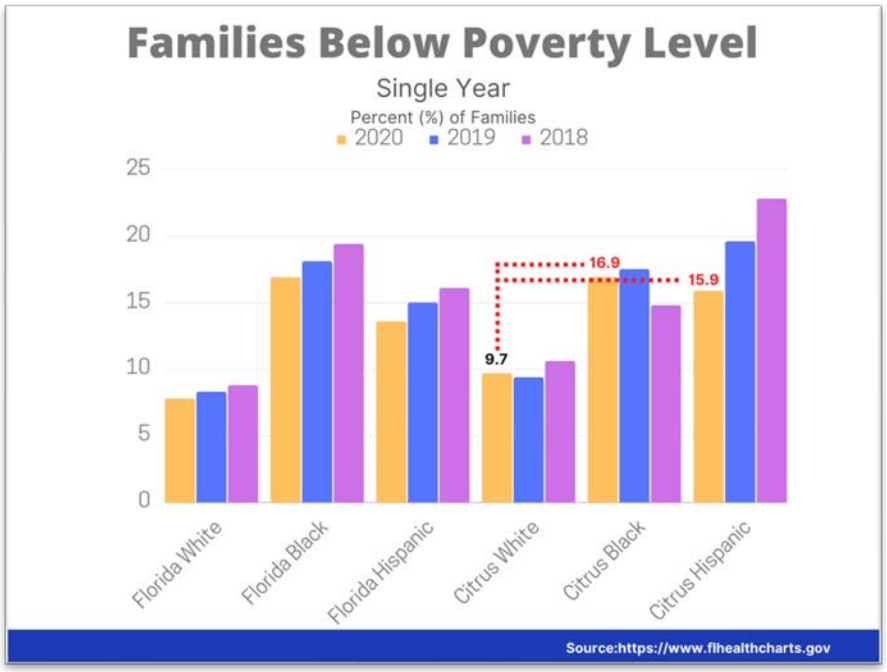
can reduce poverty and improve health and well-being). Poverty is both a cause and a consequence of poor health that increases the chances of poor health, which in turn, traps whole communities in poverty. The cost of doctors' fees, prescriptions, and transportation to reach a health provider can be devastating for families living in poverty. Conversely, families with higher incomes can more easily purchase healthy foods, pay for health services, and have transportation. To improve diabetes, Citrus County is addressing ethnic disparities related to household income.


Median Household Income
Single Year
Dollars ($)
2020
75,000
50,000
25,000
0
$45,691
$38,723
Florida Hispanic
Florida Non-Hispanic
Citrus Non-Hispanic
Citrus Hispanic
Source:https://www.flhealthcharts.gov


Median Household Income
Single Year
Dollars ($)
2020
2019
2018
75,000
50,000
25,000
0
$45,691
$38,723
Florida Hispanic
Florida Non-Hispanic
Citrus Non-Hispanic
Citrus Hispanic
Source:https://www.flhealthcharts.gov

Poverty Level

In 2019, the percentage of families below poverty level in Citrus County was 10.1% compared to Florida at 10.0%. The percentage of Hispanic families who were below the poverty level in Citrus County was 19.6%, compared to non-Hispanic individuals at 8.9%. The line graph shows change over time. Low-income limits access to healthy foods, quality healthcare, quality housing, and other resources that lead to poor health outcomes and an increased risk of developing chronic diseases. To improve diabetes outcomes, Citrus County is addressing ethnic disparities related poverty.



Source: Florida Charts

- **The impact of economic stability on chronic diseases**

Economic Stability		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Employment	Low-income, Black, Hispanic, other minority populations	Limited employment options can increase financial burdens and limit the ability to pay for health care, healthy food, transportation, housing, etc.; all of which play a role in health outcomes.

Income	Low-income, Black, Hispanic, other minority populations	Low-income limits access to healthy foods, quality healthcare, quality housing, and other resources that lead to poor health outcomes and an increased risk of developing chronic diseases.
Expenses	Low-income, Black, Hispanic, other minority populations	Mounting expenses can lead individuals to delay seeking medical care due to cost. Delayed medical care prevents prevention and the long-term management of diabetes.
Debt	Low-income, Black, Hispanic, other minority populations	Access to education and community resources aimed at increasing financial literacy can decrease the probability that an individual has of accumulating debt. Debt can be a detriment to the health of an individual by preventing access to healthcare, healthy foods, housing etc. These barriers increase poor health outcomes and increase the risk of developing chronic diseases such as diabetes.
Medical Bills	Low-income, Black, Hispanic, other minority populations	Being unable to pay down medical bills can further discourage individuals from continuing to seek medical care preventing continuity of care and their successful management of diabetes and chronic diseases.
Support	Low-income, Black, Hispanic, other minority populations	Community support and resources can provide individuals with education and the tools to manage diabetes and other chronic diseases.
Hunger	Low-income, Black, Hispanic, other minority populations	There is a strong link between hunger and chronic disease. Increasing healthy food access can lower the risk of developing chronic disease such as diabetes.

C. Neighborhood and Built Environment

- **Neighborhood and built environment data for Citrus County**

Food Insecurity

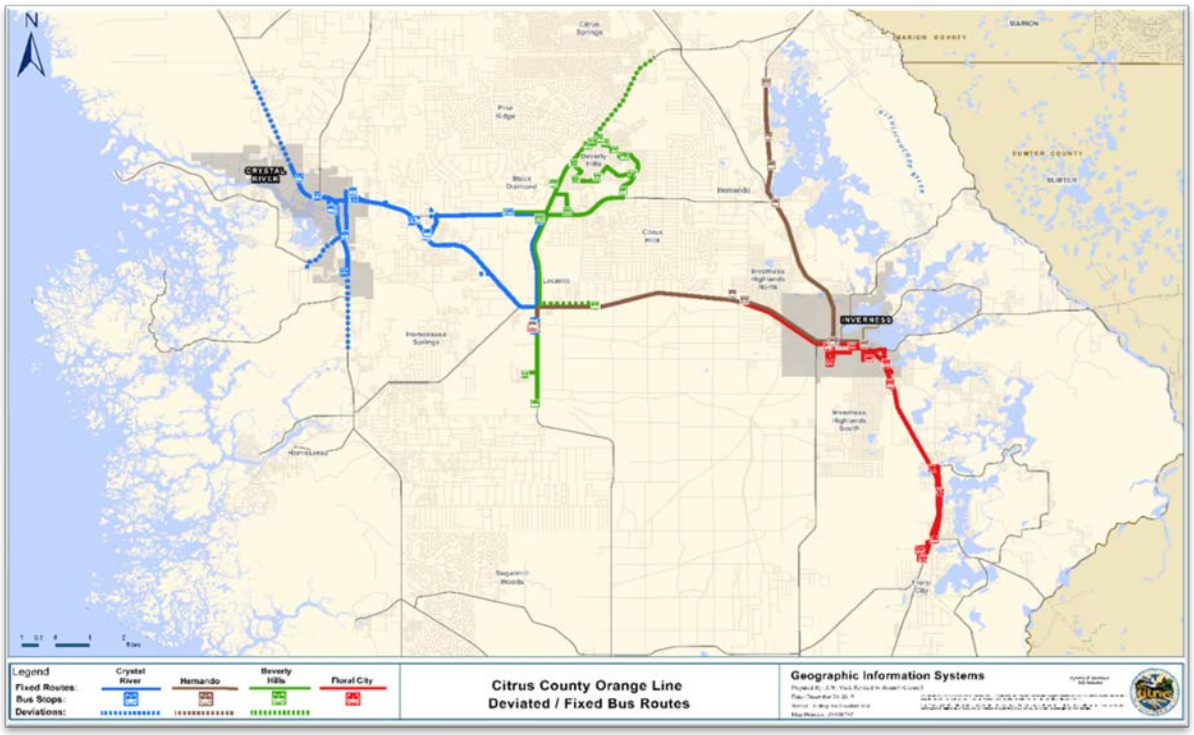
In 2021, food insecurity in Citrus County, defined as the percentage of the population who lack adequate access to food, was 16% compared to the Florida average of 13%. Further, the food environment index in Citrus County, defined as the index of factors that contribute to healthy food environment, from 0 (worst) to 10 (best), was 6.6, compared to Florida at 6.9. Finally, the percentage of the population with limited access to healthy foods was 13% compared to Florida's average of 7%. Having access to food, especially nutritious food, impacts diabetes. To improve diabetes outcomes, Citrus County is addressing ethnic disparities related to food insecurity (County Health Rankings).

Access to Exercise Opportunities

In 2021, the percentage of the population of Citrus County with access to exercise opportunities was 73%, much lower than the Florida average of 89%. Access to exercise opportunities has shown to decrease instance of heart disease, regulate blood pressure, decreased rates of obesity and diabetes all of which are chronic diseases impacting our vulnerable populations. To improve diabetes outcomes, Citrus County is addressing ethnic disparities related access to exercise opportunities (County Health Rankings).

Transportation

Citrus County operates the Orange Line bus, with four distinct routes (see below). All 30 buses are ADA compliant for wheelchairs, equipped with bike racks, and service animals are allowed. The buses operate from 6:00am-6:00pm, Monday-Friday. Unfortunately, this leaves many hours unaccounted for, which may leave off-hours and weekend workers with few options. Depending on community circumstances, people with diabetes may face unique challenges to accessing healthcare, being active, or having a strong social support network.



Source: Citrus County, Department of Community Services, Transit Services

- **The impact of neighborhood and built environment on diabetes**

Neighborhood and Built Environment		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Housing	Low-income, Black, Hispanic, minorities	Substandard housing has been linked to poor health outcomes. Not having access to clean water, electricity, proper ventilation, heating cooling, and high levels of crowding can all increase the instance of allergies, cardiovascular disease, respiratory infections, phycological distress and other physical illnesses.
Transportation	Low-income, Black, Hispanic, minorities	Not having reliable transportation effects access to medical services, healthy foods, etc. This can lead to missed or delayed medical appointments and being forced to make subpar food choices.
Safety	Low-income, Black, Hispanic, minorities	Unsafe neighborhood conditions such as air and water pollutants, road and other safety hazards, crime rates, etc. limit resources and choices available to the

		individuals living in the community. These unsafe conditions contribute to poor health outcomes.
Parks	Low-income, Black, Hispanic, minorities	Having accessibility to parks promotes exercise and improves mental and physical health, both of which can help lower the risk of chronic diseases.
Playgrounds	Low-income, Black, Hispanic, minorities	Accessible playgrounds promote exercise, improve mental health, and provides opportunities for children and their families to socialize. Staying active decreases, the risk of obesity, heart disease, diabetes, and other chronic diseases later in life.
Walkability	Low-income, Black, Hispanic, minorities	Ensuring there are safe walking trails and sidewalks improves access to neighborhood resources.
Geography	Low-income, Black, Hispanic, minorities	Where in the county individuals live can directly impact their health outcomes. The negative effects are compounded when the individuals who live in rural areas also have issues with transportation, access to healthy foods and other social resources linked to poor health outcomes.
Access to nutritional food	Low-income, Black, Hispanic, minorities	Not having access to healthy foods increases the risk of developing diabetes, hypertension, anemia, coronary heart disease, obesity and many others chronic conditions and diseases.

D. Social and Community Context

- **Social and community context data for Citrus County**

Community Engagement

Citrus County operates four Senior Community Centers, in Central, East, and West Citrus County as well as the Hernando Area. The centers provide meals, activities, health education and screenings, classes, and more. The friendly atmosphere brings light to Citrus County's senior citizens (Citrus County Department of Community Services). Access to community engagement impacts diabetes outcomes and leads to so many positive outcomes and benefits for organizations and the wider community. When an organization engage with communities, better, more informed decisions can be made, because the big picture is seen, analyzed, and action can be taken to improve the management and outcomes related to diabetes diagnosis and management. Community engagement can take the form of organized groups, agencies, institutions, or individuals. Collaborators may be engaged in health promotion, research, and even policy making. The social context of diabetes management includes multiple resources, including family (parents, spouses), peers, romantic partners, and health care providers. We discuss how these social resources change across the life span, focusing on childhood and adolescence, emerging adulthood, and adulthood and aging (https://www.apa.org/pubs/journals/releases/amp-a0040355.pdf).

Stress

Asset Limited, Income Constrained, Employed (ALICE) workers in Citrus County are typically forced to make tough decisions that may promote stress. The ALICE report measures three critical trends: cost of living, worker vulnerability, and the number of households in poverty. In Citrus County, ALICE workers make up 54% of the population, compared to the Florida average of 46% (unitedforalice.org). Stress affects physical and overall health and includes mental health, substance abuse, and suicide risk. Stress issues are symptoms of real, physical conditions occurring in the brain and can be addressed through stress abating programs, suicide prevention, and substance abuse interventions. Stress plays a vital role in our well-being. Community engagement focused on abating stress fosters following standard diabetes-related advice to eat healthy, get exercise, and manage stress (https://www.niddk.nih.gov/health-information/professionals/diabetes-discoveries-practice/the-role-of-the-community-environment-in-managing-diabetes-risk).

- **The impact of social and community context on diabetes**

Social and Community Context		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Social Integration	Low-income, Black,	Findings identify two dimensions of social relationships—warmth and control—that have implications for

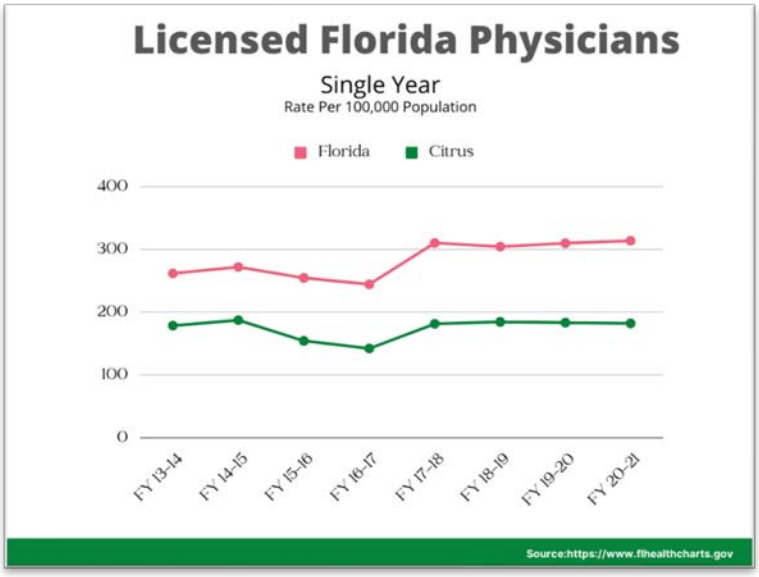
	Hispanic, minorities children, adolescents, and adults	families of children and adolescents with T1D. Consistent with the interpersonal framework and SDT, warm and friendly interactions with family and friends are related to good diabetes outcomes, whereas conflictive interactions are related to poor outcomes. Aspects of social control are more complex, potentially disrupting diabetes self-care if basic needs for autonomy and competence are thwarted. The benefits of autonomous support extend to the health care context, where physician behaviors that enhance competence may improve management .
Support Systems	Low-income, Black, Hispanic, minorities children, adolescents, and adults	Resources include family (parents, spouses), peers, romantic partners, and health care providers. Social resources change across the life span, focusing on childhood and adolescence, emerging adulthood, and adulthood and aging. High social support and low social control can promote long term diabetes management behaviors across time Critical for parents and other adults to rapidly master and teach others about their child's diabetes management.
Community Engagement	Low-income, Black, Hispanic, minorities children, adolescents, and adults	Parental responsibility for management declines and peer influences increase as a child moves to teenager and then adulthood. Peers either provide emotional support and companionship or they may undermine diabetes care. The diabetic may even alter or neglect their illness to reduce stigma or increase peer acceptance
Discrimination	Low-income, Black, Hispanic, minorities children, adolescents, and adults	Warm and friendly interactions with family and friends are related to good diabetes outcomes, whereas conflictive interactions are related to poor outcomes. Social interactions may disrupt diabetes self-care when autonomy and competence are thwarted. Benefits of autonomous support extend to the health care context, where physician behaviors can enhance competence and improve management of diabetes .
Stress	Low-income, Black, Hispanic, minorities children, adolescents, and adults	Children to adults with diabetes constantly work to help the child achieve optimal blood glucose levels and avoid hypoglycemia while facilitating normal development. Parents may experience psychosocial difficulties as they adapt to these disruptions in their roles, family routines, and future expectations.

E. Health Care Access and Quality

- **Health care access and quality data for Citrus County**

Provider Availability

For the 20-21 FY, the rate of licensed physicians per 100,000 population in Citrus County was 182.3 compared to Florida's average of 314.0. The line graph shows change over time. Lack of licensed physicians impacts diabetes outcomes by a decrease of preventive and primary care services. The impact of delayed health care due to insufficient providers to see patients may lead to poor health outcomes. Providers may not accept certain health care plans and some patients may not have health insurance causing a delay seeking care when they are ill or injured, and they are more likely to be hospitalized for chronic conditions such as diabetes. Additionally, children without health insurance are less likely to have parents with health insurance thereby delaying diagnosis and treatment of diabetes. Overall, having providers that accept health insurance of diabetic patients increases the use of health services and improves health outcomes. To improve diabetes outcomes, Citrus County is addressing disparities related to provider availability expanding the number of providers in the Doctors' Free Clinic which would allow expansion of hours of operations. Aware of the numbers of professionals or facilities within a geographic area helps to focus on the availability of health care and its quality of care. Lack of provider availability affects the social determinants of health related to economic stability, education access and quality, health care access and quality, neighborhood and built environment. Access to primary care is a key issue in health care access and quality domain (Healthy People 2030).



Mental Health Providers

In 2021, there was only 1 mental health provider per 1,500 people in Citrus County, compared to Florida's average of 1 per 590 Floridians. Lack of mental health providers impacts diabetes outcomes by not having sufficient provider resources to support the patient with diabetes. With access to mental health providers, residents can address their emotional, psychological, and social well-being. Improving mental health has positive effects for both the individual and the community. To improve diabetes outcomes, Citrus County is addressing disparities related to provider availability (County Health Rankings).

- **The impact of health care access and quality on diabetes**

Health Care Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**

Health Coverage	Low-income, Black, Hispanic, and other minority populations.	Absence of health coverage prevents vulnerable populations from obtaining primary and specialty care for long-term management of chronic diseases, such as diabetes.
Provider Linguistic and Cultural Competency	Black, Hispanic, and other minority populations.	Health services that lack cultural competency and are not provided in a language that a client can comprehend, the care provided is not effective and becomes a barrier to management of chronic diseases, such as diabetes.
Provider Availability	Low-income, Black, Hispanic, and other minority populations.	Management of chronic diseases like diabetes becomes increasingly difficult when clients don't have access to primary and specialty care providers in their community.
Quality of Care	Low-income, Black, Hispanic, and other minority populations.	Ensuring our health care systems provide equitable care, are patient-centered, provide evidence-based treatment and work cooperatively together to maintain continuity of care is essential in the management of chronic disease like diabetes.

VIII. SDOH PROJECTS

The Minority Health Liaison recruited and engaged members across the county, including government agencies, nonprofits, private businesses, and community organizations, to join the Health Equity Task Force. The Minority Health Liaison took into consideration the prioritized health disparity and the impactful SDOHs identified by the Health Equity Team during recruitment.

The Regional Health Equity Coordinator and Minority Health Liaison are working together to design and facilitate the Health Equity Task Force workshops. The workshops will be engaging, interactive, and equitable. In the workshops, Health Equity Task Force members will: 1) write a shared vision for the Health Equity Plan (completed), 2) review data on the prioritized health disparity and the SDOH that contribute to the disparity (the Health Equity Team created and facilitated a presentation), 3) identify barriers to addressing the SDOH, 4) design evidence-based projects to address the SDOH that impact the prioritized health disparity, and 5) write objectives with measurable indicators.

A. Data Review

The Health Equity Task Force will review data, including health disparities and SDOHs, provided by the Health Equity Team. The Health Equity Task Force will also research evidence-based and promising approaches to improve the identified SDOHs.

B. Barrier Identification

Members of the Health Equity Task Force will work collaboratively to identify their organizations' barriers to fully addressing the SDOHs relevant to their organization's mission. Common themes are being explored as well as collaborative strategies to overcome barriers.

The potential project has been identified within the chronic disease of diabetes to address to among other SDOHs access to care, transportation, and diabetic

education inequities. Project 1 will address Access to Healthcare with the goal of increased participation by community members at high risk for diabetes and those who have been diagnosed with diabetes. To support an increase in participation it is incumbent to increase the number of providers and expand the available days and hours for appointments. Evidence supports improved and increase in referrals to the Doctors' Free Clinic for nutrition and diabetes counseling and education to the uninsured is warranted. Transportation is a barrier that has been expressed by the community to Coalition members, specifically among rural and minority populations. The project will address Infrastructure, Partnerships, and Planning inclusive of an existing 6-week, free of charge Diabetic Education course that includes nutrition, cooking demonstrations, crock pot and pressure cooker training. DOH-Citrus County has one certified diabetic educator currently providing this service. The YMCA course has a $500 course fee that is seen as a barrier to accessing the course . Nutritionist in the WIC program are to be present during the course therefore there is a need to fund in other ways. University of Florida/Institute of Food and Agricultural Sciences (IFAS) offers cooking demonstrations, crock pot and pressure cooker training (https://ifas.ufl.edu/). Langley Health Services Federally Qualified Health Centers (FQHC) provides information to clients free of charge (https://langleyhealth.com/). Doctors' Free Clinic provides a nutrition and diabetic counseling and education to the uninsured. Department of Health will fund the training of two additional diabetes health educators to facilitate additional free Diabetes Education courses to community members within Citrus County. The critical components of this project will be to include community partners, SDOHs, partner barriers, recurring themes, and collaborative strategies.

C. Community Projects

The established framework to design this project is Health in All Policies (HiAP) - a collaborative approach integrating health considerations into policymaking at the national, state, territorial, and local health department levels to improve the health of all communities and people proactively and retroactively. An example is

the Citrus County Board of County Commissioners (BOCC) and cities within Citrus County that have committed to include DOH-Citrus County in projects that have a health component. The HiAP approach provides one way to achieve the National Prevention Strategy and Healthy People 2030 goals to improve health outcomes. The HiAP approach may also be effective in identifying gaps in evidence and achieving health equity. The HiAP framework provides a way to improve health and well-being most effectively by integrating recommendations and actions across multiple settings to focus on both increasing the length of people's lives and ensuring that their lives are healthy and productive. HiAP prescribes a call to action from promoting healthy behaviors to creating environments that make it easier to exercise and access healthy foods (https://www.cdc.gov/policy/hiap/index.html).

The Health Equity Task Force researched evidence-based strategies to overcome the identified barriers and improve the SDOH that impact the prioritized health disparity. The Health Equity Task Force will use this information to collaboratively design community projects to address the SDOHs. Projects included short, medium, and long-term goals with measurable objectives. These projects are to be reviewed, edited, and approved by the Coalition to ensure feasibility.

Projects will include short, medium, and long-term goals with measurable objectives the Task Force is using to assess the success of each project. The use of project management/implementation plans is anticipated to track specific activities to address each identified SDOH.

IX. HEALTH EQUITY PLAN OBJECTIVES

Each project will have tables like the one provided below to measure improvements related to the health disparity. Under each health disparity objective will be short-term, medium-term, and long-term SDOH goals. Each goal will have at least one SDOH objective to measure if the goal was met.

A lead entity and relevant sub-units for each SDOH objective will have an assigned point person with specifics related to the data source for indicators. Alignment with other plans such as the Strategic Plan, Community Health Improvement Plan, Performance Management and Quality Improvement Plan, and the Emergency Operations Plan will be incorporated.

A. Prioritized Health Disparity

- **Health Disparity Objective:** By July 2024, increase number of trained diabetes educators withing Citrus DOH from 1 to 3. By July 2024, Reduce the burden of diabetes and improve quality of life for all people who have, or are at risk for diabetes by increasing infrastructure, partnerships, and planning to reflect the most current practices to “Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all incorporating social determinants (Healthy People 2030).”

- **Project 1: Increase the Health Care Access and Quality of Health Care for Diabetes Patients by** 1) increasing the number of providers in the Doctors’ Free Clinic from one provider to three providers; 2) expanding the available appointment days and times from a half day one Saturday per month to three full days each month; 3) Collaborate with County Public Transportation Services to increase the current hours of Monday–Friday 6 AM – 6 PM to more align with the needs of the community for access to the

Doctors' Free Clinic, and 4) increasing the number of certified instructors and the number of offerings per year for the Diabetic Education and Management course. [Data source: DOH-Citrus County, Doctors' Free Clinic, Citrus County Public Transportation Services].

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve Health Care Access and Quality of Health Care for Diabetes Patients.						
Objective: By 7/2024, Increase the number of providers in the Doctors' Free Clinic from 1 to 3 to provide comprehensive, high-quality health care services for diabetic patients.	Doctors' Free Clinic Citrus (DFCC)	Karla Poulos & Dr. Jeff Wallis	Doctor's Free Clinic	1provider, 4 hours, 1st Saturday each month	3 providers, 3 full days per month	CHIP, CHA
Medium-Term SDOH Goal: By 7/2023, Increase the number of providers in the Doctors' Free Clinic from 1 to 2						
Objective: By 6/2023, Improve Health Care Access and Quality of Health Care increasing to 3 providers, 3 days per month	Doctors' Free Clinic Citrus (DFCC)	Karla Poulos & Dr. Jeff Wallis	Doctor's Free Clinic	2 provider, 4 hours, 1st Saturday each month	3 providers, 3 days per month	CHIP, CHA

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Short-Term SDOH Goal: Improve Health Care Access and Quality of Health Care						
Objective: By 12/2022, identify current number of diabetic patients being seen, assess capacity for additional patient/provider ratios.	Doctors' Free Clinic Citrus (DFCC)	Karla Poulos & Dr. Jeff Wallis	Doctor's Free Clinic	Unknown	Unknown	CHIP, CHA

Long-Term SDOH Goal: Improve Health Care Access and Quality of Health Care by expanding the available appointment days and times from ½ day one Saturday per month to 2-3 full days per month. Allow for potential of other resources to meet this perceived need in the community.						
Objective: By 7/2024, expanding the available appointment days and times from ½ day one Saturday per month to 2-3 full days per month.	Doctors' Free Clinic Citrus (DFCC)	Karla Poulos & Dr. Jeff Wallis	Doctor's Free Clinic	4 hours per month	24 hours per month	CHIP, CHA
Medium-Term SDOH Goal: Improve Health Care Access and Quality of Health Care of Diabetic Patients by expanding the available appointment days and times						

from ½ day one Saturday per month to 2-3 full days per month. Allow for potential other resources to meet this perceived need in the community						
Objective: By 7/2024, expanding the available appointment days and times from ½ day one Saturday per month to 2 full days per month.	Doctors' Free Clinic Citrus (DFCC)	Karla Poulos & Dr. Jeff Wallis	Doctor's Free Clinic	4 hours once per month	16 hours per month	CHIP, CHA
Short-Term SDOH Goal: Improve Health Care Access and Quality of Health Care of Diabetic Patients by expanding the available appointment days and times from ½ day one Saturday per month to 8 hours per month.						
Objective: By 12/2022, identify Neighborhood and Built Environment expanding the available appointment days and times from 4 hours one Saturday per month to 8 hours per month.	Doctors' Free Clinic Citrus (DFCC)	Karla Poulos & Dr. Jeff Wallis	Doctor's Free Clinic	4 hours	8 hours	CHIP, CHA

Long-Term SDOH Goal: Improve Social and Community Context to Collaborate with County Public Transportation Services to increase the current Monday – Friday, 6 AM – 6 PM service hours to more align with the needs of the community for access to the Doctors' Free Clinic						
Objective: By 7/2024, increase Social and Community	HE Liaison, Citrus County Transit Services, &	Vanessa Verdo & Karla Poulos & Dr. Wallace	Transportation Disadvantaged Program (TDP)	O hours on Saturday	8 hours on Saturday	

Context through collaboration with County Public Transportation Services to increase service hours	Doctors' Free Clinic					
Medium-Term SDOH Goal: increase Social and Community Context collaboration with County Public Transportation Services to increase the current Monday – Friday 6 AM – 6 PM service hours to more align with the needs of the community for access to the Doctors' Free Clinic						
Objective: By 6/2023, increase County Public Transportation Services to more align with the needs of the community for access to the Doctors' Free Clinic	HE Liaison & Citrus County Transit Services CHD-Citrus County	Karla Poulos, Dr. Wallace, Vanessa Verdo & BJ Ezell	Citrus County Transit Services Transportation Disadvantaged Program (TDP), & DFCC	DOH-Citrus County vehicles not used to transport patients to DFCC or diabetes education	Plan for transport to/from DFCC and diabetes classes	
Short-Term SDOH Goal: Improve Social and Community Context collaboration with County Public Transportation Services to increase current Monday–Friday, 6 AM – 6 PM service hours to more align with the needs of the community for access to the Doctors' Free Clinic and Diabetes Education course.						
Objective: By 12/2022, identify County Public Transportation Services hours	HE Liaison & Citrus County Transit Services CHD-Citrus County	Karla Poulos, Dr. Wallace, Vanessa Verdo & BJ Ezell	Citrus County Transit Services Transportation Disadvantaged Program (TDP), & DFCC Transit	Confirm DFC contacts' awareness of transit hours compared to DFC hours of operation	Advocate for County Transit schedule to coincide with DFCC's current schedule	DFCC

Long-Term SDOH Goal: Economic Stability for people with diabetes by referring diabetic patients to resources that assist with steady incomes or the provision of additional income to meet their health needs.						
Objective: By 9/2023, increase Economic Stability by referring diabetic patients to resources for people to earn steady incomes or gain additional income to allow them to meet their health needs.	Citrus County Referral Services Representatives	HE Liaison	Healthy People 2030	Absence of Employment programs, career counseling, and high-quality childcare	Identification of referrals Services including Employment programs, career counseling, and high-quality childcare	Healthy People 2030
Medium-Term SDOH Goal: Economic Stability for people with diabetes by referring diabetic patients to resources that assist with steady incomes or the provision of additional income to meet their health needs.						
Objective: By 6/2023, Economic Stability by referring diabetic patients to resources for people to earn steady incomes or gain additional income to allow them to meet their health needs.	Citrus County Referral Services Representatives	HE Liaison	Healthy People 2030	Absence of Employment programs, career counseling, and high-quality childcare	Identification of referrals Services including Employment programs, career counseling, and high-quality childcare	Healthy People 2030
Short-Term SDOH Goal: Economic Stability for people with diabetes by referring diabetic patients to resources that assist with steady incomes or the provision of additional income to meet their health needs.						

Objective: By 12/2022, identify Economic Stability opportunity referral sources	Citrus County Referral Services Representatives	HE Liaison	Healthy People 2030	Absence of Employment programs, career counseling, and high-quality childcare	Identification of referrals Services including Employment programs, career counseling, and high-quality childcare	Healthy People 2030

Long-Term SDOH Goal: Diabetes Education Access						
Objective: By 7/2024, Increase the proportion of people with diabetes who get formal diabetes education	Community Health	Carmen Hernandez	Citrus County diabetes education and management statistics. Diabetes education and self-management course statistics	6-week free diabetes education course verses 12-month course offered __ times per year. And number of certified diabetes educators	Offer education course __ times per year and increase number of certified educators to 3	CHIP, CHA
Medium-Term SDOH Goal: Improve Diabetes Education & Management Course (DEMC) from (baseline value) to (target value).						
Objective: By 7/2023, implement Diabetes Education & Management Course (DEMC) from _ per year to __ per year	Community Health	Carmen Hernandez	Diabetes Education and Management Statistics	6-week Diabetes Education Course offered __ times per year by ___ number of certified diabetes educators	6-week Diabetes Education Course offered __ times per year by ___ number of certified diabetes educators	CHIP, CHA

Short-Term SDOH Goal: Ensure educational topics are aligned with a certified National Diabetes program						
Objective: By 12/2022, Review formal diabetes education.	Community Health Coordinator	Carmen Hernandez	Diabetes Course records. Citrus County diabetes course records	Ensure topics of healthy eating, physically active, taking medicine, blood sugar checks, reducing risk for other health problems, and learning to cope with stress, depression, and other concerns are included.		CHIP, CHA

X. PERFORMANCE TRACKING AND REPORTING

Ongoing communication is critical to the achievement of health equity goals and the institutionalization of a health equity focus. The successes of Health Equity Plan projects are shared with OMHHE, partners, other CHDs, CHD staff, and the Central Office through systematic information-sharing, networking, collecting, and reporting on knowledge gained, so that lessons learned can be replicated in other counties and programs. Regional Health Equity Coordinators facilitate systematic communication within their region.

A reporting software tool, ClearPoint, is used to enter data and report Health Equity Project Management information. This method of data collection will allow for easier reporting and tracking of the HE Plan development. A live 2-hour training session was provided to allow the Minority Health Liaison real time learning and question and answer having the CHD's real time data available.

The Minority Health Liaison serves as the point of contact in their county for sharing progress updates, implementation barriers, and practices associated with the Health Equity Plan. The Minority Health Liaison is responsible for gathering data and monitoring and reporting progress achieved on the goals and objectives of the Health Equity Plan. At least quarterly, the Minority Health Liaison meets with the Health Equity Task Force to discuss progress and barriers. The Minority Health Liaison tracks and submits indicator values to the OMHHE within 15 days of the quarter end.

Annually, the Minority Health Liaison submits a Health Equity Plan Annual Report assessing progress toward reaching goals, objectives, achievements, obstacles, and revisions to the Regional Health Equity Coordinator and Coalition. The Regional Health Equity Coordinator and Coalition leaders provide feedback to the Minority Health Liaison and the Health Equity Task Force from these annual reports. The Minority Health Liaison then submits the completed report to OMHHE by July 15th annually.

XI. REVISIONS

Annually, the Health Equity Task Force reviews the Health Equity Plan to identify strengths, opportunities for improvement, and lessons learned. This information is then used to revise the plan as needed.

Revision	Revised By	Revision Date	Rationale for Revision

Appendix A: National Minority Health Equity Month Proclamations and Pictures

Board of County Commissioners of Citrus County, Chairman Ronald E. Kitchen, Jr. (far right)

City of Crystal River, Mayor Joe Meek (far left)

City of Inverness, Mayor Bob Plastid (far right)

Health Equity Plan Publication Authorization

I have thoroughly reviewed the Health Equity Plan for County. The plan has been edited for spelling, grammar, and formatting issues. It meets the Health Equity Plan Standards. It is ready for public viewing on the Office of Minority Health and Health Equity website.

KD	7/29/2022
Minority Health Liaison	Date
	29 July 2022
Regional Health Equity Coordinator	Date
Ernesto G. Rubio Digitally signed by Ernesto G. Rubio DN: cn=Ernesto G. Rubio, o=DOH-CITRUS, ou=Administrator/Health Officer, email=Tito.Rubio@flhealth.gov, c=US Date: 2022.07.29 11:39:05 -04'00'	7/29/22
Health Officer	Date
Amy Douglas	7/29/22
Public Information Officer	Date